**OBJECTIVES**

* Briefly review types of advanced directives.
* Describe problems with advanced directives.
* Discuss the physician􏰁s role at the end of life.

**Types of Advanced Directives**

* Do Not Resuscitate (DNR)
* Living Will
* Health Care Proxy (Durable Power of Attorney for Health Care)
* POLST/MOLST (Physician/Medical Orders for Life-Sustaining Treatment)

**Do Not Resuscitate (DNR)**

* Do Not Resuscitate (DNRCC)
  + DNR Comfort Care Protocol activated immediately
* • DNRCC-Arrest (DNRCC-A)
  + DNR Comfort Care Protocol implemented in the event of a cardiac or respiratory arrest

**DNRCC Protocol**

* Will
  + Suction the airway
  + Administer oxygen
  + Position for comfort
  + Splint or immobilize
  + Control bleeding
  + Provide pain medication
  + Provide emotional support
  + Contact appropriate health care providers
* Will not
  + Administer chest compressions
  + Insert artificial airway
  + Administer resuscitative drugs
  + Defibrillate or cardiovert
  + Provide respiratory assistance (other than that listed above)
  + Initiate resuscitative IV
  + Initiate cardiac monitoring

**DNR**

* Can be revoked, at any time, by the patient or the patient􏰁s family/health care power of attorney.

**Living Will**

* Patients direct the physician to withhold or withdraw life-sustaining treatment if they develop a terminal condition.
* Some disagree on whether this includes antibiotics.
* Some states do not allow patients to decline artificial nutrition and hydration through living wills.
* Is more detailed about what you don't want for a long period of time
* has to do with long term care

**Durable Power of Attorney for Health Care**

* Health care proxy makes medical decisions, in the event the patient loses decision-making capacity.
* Some states limit who can serve in this capacity. – May not be treating physician or employees of
  + treating physician, unless related to patient.
* Should supplement with Living Will or similar statements of treatment wishes.

**POLST/MOLST**

* Vary by state (Oregon is paradigm)
* Five sections
  + A. CPR
  + B. Medical interventions
  + C. Antibiotics
  + D. Artificially administered nutrition
  + E. Reason for orders/signatures

**CPR**

* Attempt resuscitation/CPR
* Do not attempt resuscitation (allow natural death)
* When not in cardiopulmonary arrest, follow B,C and D.

**Medical Interventions**

* Comfort measures only
  + Medications by any route, change positions, wound care to relieve pain
  + Oxygen, suction and manual treatment of airway obstruction
  + Do not transfer to hospital, unless comfort care needs cannot be met
* Limited additional interventions
  + Above, plus medical treatment, IV fluids and cardiac monitoring as indicated
  + No intubation, advanced airway interventions or mechanical ventilation
  + May consider CPAP or BiPAP
  + Transfer to hospital if indicated
  + Avoid intensive care
* Full treatment
  + Care as above
  + Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated
  + Transfer to hospital if indicated
  + Includes intensive care

**Antibiotics**

* No antibiotics
* Determine use/limitation of antibiotics when infection occurs
* Use antibiotics if medically indicated

**Artificially Administered Nutrition**

* No artificial nutrition by tube
* Defined trial period of artificial nutrition by tube
* Long-term artificial nutrition by tube

**Limitations of Advanced Directives**

* Patients and their families might not be ‘informed.’
* They rarely understand what is entailed by mechanical ventilation or CPR
  + 86% of people who receive CPR die
  + CPR complications (very rare to get patients back and if you do other complications may be obtained)
    - Anoxic brain injury, rib fractures
    - Ventilated patients are not always unconscious
    - Ventilated patients cannot speak
* People with metastatic disease overestimate their likelihood of survival
* Vague terms (‘heroic’ or ‘extraordinary’) are ambiguous.
  + Are feeding tubes ‘extraordinary’?
  + IV antibiotics?
  + CT scans?
* People change their minds.
  + It is easy to refuse intubation when you are not short of breath.
* Try it when you are dying and suffering from air hunger!
  + Families often panic

**Problems with Proxies**

* Reasonable people acting in good faith can still disagree about what is best for the patient.
* Family members and physicians may not accurately state the patient􏰁s wishes.

**Acting in the Patient’s Best Interest**

* When patients do not have advanced directives
* When a patient changes his mind
  + What if a patient, now demented, makes choices that differ from earlier directives?
* Often ethics committees can be helpful in making such decisions

**Improving Discussions of Advanced Directives**

* It’s better to discuss them when patients are feeling well--not in a crisis.
  + Patients feel they have greater control at such times.
* Discuss them with patients who have chronic illnesses.
* Patients prefer that their physician initiate the conversation.
* Physicians are in a position to help patients understand what advanced directives can and cannot do.

**Items for Discussion**

* Emphasize that Do Not Resuscitate does not mean Do Not Treat.
* You can change your mind!
* Encourage patients to discuss their wishes with their family.
* Remind patients and family members to have copies of their DNR and Living Wills available for emergencies.

**The Physician’s Role at the End of Life**

* Social commitment of the physician is to sustain life and relieve suffering.
* Where the two conflict, the patient􏰁s preference prevails.

**What if You Disagree?**

* Ethics Committee consultation?
* Remove yourself from the case?
* Other options?

**Case 1: End-Stage CHF**

* Mr. B is a 72 year-old Caucasian male who has been short of breath for 3 days and complains of chest pressure.
* He is too short of breath to speak, and is gasping for breath, with audible rales.
* His family is at his side, and they state that he 􏰂has a living will􏰃 and 􏰂does not want to be on any machines.􏰃
* Mr. B’s respiratory rate is 45, his heart rate is 135 and he is diaphoretic.
* His respiratory efforts are weak and he appears to be rapidly fatiguing.
* *What should you do?*

**Case 2: Alzheimer’s Dementia**

* Mrs. G is a nursing home resident, brought to the emergency department for a change in mental status.
* She is accompanied by her daughter who is the patient􏰁s medical decision-maker.
* She has a history of dementia and multiple admissions for aspiration pneumonia.
* Case 2
* The patient moans to pain, but is otherwise nonresponsive
* Her vital signs are stable and she is protecting her airway
* The daughter states that at baseline, the patient scoots around the nursing home in her wheelchair and feeds herself a soft diet with thickened liquids, but is not oriented to current events.
* The daughter wants everything done because a life is a life.
* A chest X-Ray confirms a new right-sided pneumonia.
* The daughter asks if a feeding tube can be placed to prevent future aspiration
  + Note: G-tube (feeding tube) will not change her risk of aspiration
* *How do you advise the daughter?*

**Case 3: Newborn with Omphalocele and Down Syndrome**

* Baby A is a newborn of 37 week’s gestation. She was born via C-section, because the obstetrician noted an omphalocele (guts are outside of your body ) on ultrasound, obtained in the OB suite.
* There was no prenatal care
* Genetic testing also confirms Trisomy 21.
* The pediatric surgeons explain the need for an operation to repair the omphalocele.
* The mother wishes to refuse the surgery and let nature take its course.
* *How would you respond?* 
  + Omphalacele can effectively treat the patient.
  + Parent might be scared and not want to take care of a downs baby.

**Case 4: Metastatic Cancer**

* Mr E has been diagnosed with prostate cancer that has metastasized to his spine.
* He is receiving Hospice care at home.
* His wife called the ambulance because the pain medicine he is receiving does not seem to help and it is 3:30 am.
* On exam, you note an emaciated male, moaning in pain, but not oriented to place or event.
* *What is your plan of care?*

**Case 5: Post-Operative Heart**

* Mrs. L had a long history of CAD, with a prior 4-vessel CABG.
* During a revascularization procedure (re-do CABG) the patient suffers an apparent stroke in the OR and fails to awaken in the post-operative SICU.
* She is unable to be taken off of the ventilator and is unresponsive.
* At the time of surgery, she was a full code.
* *What would you like to discuss with Mrs. L’s family?*

**Palliative Care (relief of symptoms, managing pain, in accordance with beliefs etc)**

* Hospice and Palliative Care Medicine is the newest Board Certified medical specialty.
* Approved by:
  + American Board of Medical Specialties
  + Physical Medicine and Rehabilitation
  + Psychiatry
  + Neurology
  + Surgery
  + Pediatrics
  + Radiology
  + Obstetrics and Gynecology
  + Emergency Medicine
  + Board of Internal Medicine
  + Board of Anesthesiology
  + Board of Family Medicine
* For patients with chronic, progressive illness
* Have significant symptom burdens but want to continue life prolonging therapies
* Focus is on management of pain and other distressing symptoms, as well as psychosocial and spiritual care in accordance with the patient’s beliefs and cultures

**Hospice Care**

* Patients no longer pursue life-prolonging therapies
  + Patients with 6 months life expectancy or less
* Expected survival is 6 months or less
* Can be provided at home or in a nursing home
* Philosophy of care that accepts death as a natural part of life
* Does not seek to prolong or hasten death

**Doctrine of Double Effect**

* All interventions have intended and unintended effects.
* DDE differentiates between effects that are intended from those that are foreseen but unintended.
* Physician is caught between relieving suffering and not causing the patient’s death.
  + some patients could die when given the medications that are needed to sustain their life and relieve their pain

**Terminal Sedation**

* Patient is sedated to unconsciousness in order to control symptoms
* All life-sustaining interventions are withheld
  + Patient dies of dehydration, starvation or intervening complications
* Widely accepted but not free of controversy
  + While sedation is intended to relieve suffering, the patient dies from withholding nutrition and fluids, not of the underlying disease

**Active Voluntary Euthanasia (AVE) --** **legal in Oregon**

* The physician administers the means of death.
  + Voluntary, because the patient requests it
  + Involuntary (when the patient opposes it) and nonvoluntary (when the patient cannot express a preference) are generally agreed to be wrong

**Physician-Assisted Suicide (PAS)**

* The patient self-administers a lethal dose of medication or activates a device to deliver the drug
* While the physician provides the means of death, the patient must carry out an independent act

**Arguments For AVE and PAS**

* Respect for autonomy
* Compassion for patients who are suffering

**Arguments Against AVE and PAS**

* Sanctity of life
* Suffering can almost always be relieved
* Requests for assisted suicide are not autonomous
* Fears of abuse

**Return to Case 1: End-stage CHF**

* Mr. B opts to not be intubated.
* He is started on BiPAP but does not tolerate it, so a NRB mask is placed.
* You order Ativan for his anxiety and Morphine for his pain, but Mr. B still appears very uncomfortable.
* You are concerned that higher doses of medications may depress his respiratory drive.
* *What do you do?*

**Return to Case 4: Metastatic Cancer**

* You give Mr. E narcotic pain medication, but he is still uncomfortable.
* His wife tells you that she wishes they lived in Oregon, where Physician-Assisted Suicide is legal.
* *What is your response?*

**Delivery of Bad News**

* It is better to deliver it in person, rather than by telephone.
* Provide a calm setting.
* Warn the person that bad news is coming.
* Avoid euphemisms.
* Allow the person to react.
* Keep the first conversation brief
* Elicit reactions and concerns using open- ended questions.
* Provide realistic hope.
* Show your concern.
* Repeat the discussion at subsequent visits.
* Share uncertainty with the patient.
* Address psychosocial concerns